GUEST EDITORIAL

Non-communicable diseases and the mental health gap: what is to be done?

Vijay Ganju

Secretary General, World Federation for Mental Health, email vkganju@gmail.com

The increasing evidence base for cost-effective interventions and a fledgling advocacy effort have given momentum to mental health becoming a global priority. The contention of this editorial is that we are at a tipping point if we can exploit the opportunities that will be afforded to mental health professionals and advocates in the next year or two. The missing links are the development of consensus among mental health stakeholders, the formation of coalitions and partnerships with both advocates and policy-makers, and the mobilisation of a stronger advocacy effort built around consumer and family member 'voice' and empowerment.

As the *Mental Health Atlas 2011* report from the World Health Organization (WHO) shows, in most countries the implementation of mental health programmes over the past decade has been glacial, if not nonexistent. While the rationale for including mental health as a priority in global and national health agendas has been strengthened and refined – as reflected in the *Lancet* series on global mental health (*Lancet*, 2007) and the paper 'Grand challenges in global mental health' (Collins *et al*, 2011) – this has not resulted in significant traction with policy-makers and national planners. Even though mental health advocates and some policy-makers presented arguments 'making the case' at the High-Level Meeting on Non-Communicable Diseases convened by the United Nations in September 2011 and the international meetings leading up to it (Ghodse, 2011; Ganju, 2011a), mental health was not included in a substantive way. This is especially disquieting because these arguments were not just general demands for the prioritisation of mental health in the policy schema, but contained specific recommendations regarding action and implementation, including treatment and programmatic interventions such as the World Health Organization's mhGAP programme (WHO, 2010a) and the infrastructural changes needed.

In the Political Declaration of the High-Level Meeting, there were several references to mental health, the most significant being the recognition 'that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programs and healthcare interventions' (United Nations General Assembly, 2011).

The rationale for the inclusion of mental health in the agenda regarding non-communicable disease (NCD) is impeccable. Mental illnesses are highly prevalent, affecting one out of every five persons each year. Neuropsychiatric disorders are estimated to contribute to 13% of the global burden of disease (WHO, 2011). Suicide claims the lives of at least one million people annually. Even in the least developed regions of the world, where infectious and parasitic diseases are prominent, mental, neurological and substance use disorders are a major burden. Over the next 20 years, it is estimated that neuropsychiatric disorders alone will account for the loss of an additional US$16.1 trillion, with 'dramatic impacts on productivity and quality of life' (Bass *et al*, 2012).

Besides the prevalence and burden argument, the other components of 'making the case' include: the link between mental health and economic and social development, as outlined in the WHO (2010b) report *Mental Health and Development*; the fact that we now have economically viable evidence-based interventions for specific mental illnesses and disorders; the humanitarian argument related to stigma, discrimination and equity; and the strong bi-directional link between mental health and NCDs such as diabetes, cancers, cardiovascular diseases and respiratory diseases (Ganju, 2011a). Mental illness is not only a risk factor for other entities, but is often a consequence of having diabetes, cancer, cardiovascular disease or respiratory disease. Here the argument is that without addressing mental and substance use disorders explicitly, outcomes related to NCD initiatives not only will be less effective but also, as the research shows, will cost more. For example, we know that people with diabetes have twice the risk of being depressed as those without the condition: treating both diabetes and depression results in improved medication adherence and lower healthcare costs.

Unfortunately, even though these arguments have been reiterated in journal articles, reports and international meetings, they have not resonated politically. The arguments are necessary but not sufficient: the expectation that the existence and presentations of the rationale will be the basis of action is, at best, wishful.

Reasons for the exclusion of mental health in the NCD agenda by policy-makers and mental health advocates include: the absence of mental health advocates at the NCD advocacy table over the past several years; the inability or unwillingness of mental health stakeholders to forge partnerships and alliances with the broader NCD coalitions; and the weakness of the 'voice' of persons with psychiatric illnesses and their family members.

Mental health advocacy related to the global NCD agenda started just a year before the United Nation's High-Level Meeting. The rationale was presented at various forums, but by then the

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course had been set, and the belated positions for mental health were hard to incorporate. Even at the WHO, where mental health is recognised as a global priority, administrators adopted a position where they acknowledged mental health but did not incorporate it fully because of the cost implications and in case the delicate balance in a series of compromises was undermined.

However, in the build-up to that UN High-Level Meeting, a foundation for future activities was laid. Under the auspices of the World Federation for Mental Health (WFMH), numerous mental health and health advocacy groups came together to present the case for mental health from a civil society perspective. The health ministers (or equivalents) of several countries – India, the USA, Uganda, South Africa, Canada, Brazil, Guyana, Liberia, to name a few – were proactive. A meeting convened by mental health advocates with several health ministers in New York on the eve of the High-Level Meeting developed positions and recommended next steps (Ganju, 2011b). These activities led to a draft resolution on mental health moved jointly by India, Switzerland and the USA for consideration by the WHO executive board meeting in January 2012. This resolution was passed and has tremendous implications for what needs to occur next, in fairly short order.

A major recommendation in the resolution is a request to the WHO Director-General 'to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes … to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community'. Several provisions are also outlined for inclusion in the action plan, which will be submitted in 2013, through the WHO executive board, for consideration by the 66th World Health Assembly.

This resolution provides impetus and direction. Some activities that need to occur in the near future include: convening representatives of mental health stakeholder groups to formulate consensus positions; developing partnerships and alliances with other NCD groups to explore how mental health and the NCD agenda can be aligned; and using existing consumer and family groups to ensure that their voice is an integral part of planning at both national and international levels. The development of a People's Charter for Mental Health (Bass *et al*, 2012) is a critical component, but this must be put in the context of a 'top-down, bottom-up' partnership between policy-makers and advocates, and lateral, horizontal alliances across both mental health and NCD stakeholder groups.

We are potentially at the cusp of a new era in mental health. We must work together to ensure that we take advantage of the opportunities that exist to make mental health truly a global priority.

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THEMATIC PAPERS

Mental health and the World Health Organization: translating strategy into practice

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email d.skuse@ucl.ac.uk

We asked the programme managers for mental health at the World Health Organization's Regional Offices for Europe, the Eastern Mediterranean and South-East Asia to provide an account of developments in the provision of mental health services within their regions.

We are very fortunate that these busy and influential individuals were able to set aside the time to prepare articles that shed a fascinating light on strategic thinking within the World Health Organization.

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